Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SELECT ANESTHESIA SERVICES
PO BOX 3945 DEPT 124
HOUSTON TX 77253

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-3566-01

MFDR Date Received
AUGUST 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Anesthesia code billed correctly based on the CPT code submitted."

Amount in Dispute: $170.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided separate monitored anesthesia services for a tranforaminal steroid injection..Dr. A. Chaurdhry, M.D., performed the injection. The requestor billed code 01936 for the anesthesia care. Texas Mutual denied payment of the code because the documentation does not substantite the use of that code…While it is true percutaneous guided imaging was used by the surgeon it is also true that two different providers were involved, i.e. one performing the injection, the other performing the anesthesia. Code 01992 is the correct match reflecting the documentation; code 01936 is a partial match. For these reasons no payment is due."

Response submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2012	CPT Code 01936-QK	$170.07	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remark code or NCPDP reject reason code).
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 714-Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Services are not reimbursable as billed.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724-No additional payment after a reconsideration of services.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to whether or not the requestor is entitled to reimbursement for anesthesida services billed under CPT code 01936.

   According to the explanation of benefits, the respondent denied reimbursement for the disputed service based upon reason codes "714, CAC-16 and 225".

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The 2012 *National Correct Coding Initiative Policy Manual For Medicare Services* CPT codes states "Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible."

   The requestor noted on the Table of Disputed Services "64483/ASA01936."

   The respondent submitted a copy of Dr. Chaudhry's report that indicates the claimant underwent "Lumbar Transforaminal Epidural Steroid Injection(s) with fluoroscopy." This procedure supports billing of CPT code 64483.

   The respondent states that "Code 01992 is the correct match reflecting the documentation; code 01936 is a partial match. For these reasons no payment is due."

   CPT code 01936 is defined as "Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic. "

   CPT code 01992 is defined as "Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position."

   The Division finds that the requestor did not support billing CPT code 01936. The procedure performed was not a radiological guided procedure. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/26/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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